zations studied. The transparency index scores were as follows: Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen/Gemeinsamen Bundesausschusses (Germany), National Institute for Health and Care Excellence (UK), pan-Canadian Oncology Drug Review (Canada), Common Drug Review (Canada), Pharmaceutical Benefits Advisory Committee (Australia), Comissão Nacional de Incorporação de Tecnologias (Brazil), Haute Autorité de Santé (France), Agencia de Evaluación de Tecnologias Sanitarias (Spain), and Agenzia Italiana del Farmaco (Italy) were 97%, 96%, 91%, 83%, 78%, 70%, 67%, 53%, and 25%, respectively. **CONCLUSIONS:** Transparency amongst HTA organizations is progressively becoming the international standard. However, the extent of transparent processes and procedures proves to be heterogeneous amongst international review organizations.

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EXPLORING THE KEY DECISION DRIVERS PROVIDED BY HTA AGENCIES REJECTING SUBMISSIONS WITH ICERS LOWER THAN THE THRESHOLD

Walsh SCM, Goodrich K

HERON Evidence Development Ltd., London, UK

OBJECTIVES: Health technology assessment (HTA) agencies use an incremental cost-effectiveness ratio (ICER) threshold generally understood to be £30,000 for NICE (England), £20,000 for the SMC (Scotland), CAN$50,000 for CADTH (Canada), and AUS$42,000 for PBAC (Australia). To help inform future submissions, we assessed the rationale provided by the four HTA agencies when submissions were rejected despite the reported ICERs being lower than these thresholds. **METHODS:** All HTA appraisals from January 2000 to May 2013 from NICE, SMC, CADTH, and PBAC were included in the analysis. Multiple technology appraisals, resubmissions, vaccination programmes, requests for advice, and submissions for which an ICER could not be determined were excluded from the analysis. The full responses of the remaining appraisals were reviewed, with the submitted ICER, recommendation, and reasoning behind the recommendation extracted. **RESULTS:** A total of 594 submissions met the inclusion criteria. 354 submissions across the four HTA bodies included a lower-than-threshold ICER, with 107 (30.2%) of these submissions rejected. Across the agencies, the most common reasons for rejection were use of an inappropriate patient population or comparator (45/107), uncertainty regarding the clinical benefits (32/107), and use of economic evidence that was not sufficiently robust (40/107). The reasons for rejection were consistent across the four agencies, with a similar proportion basing their decision at least partly on one of the three reasons provided above: NICE (92.9%), SMC (92.0%), CADTH (93.3%), PBAC (93.8%). **CONCLUSIONS:** A large proportion of submissions were rejected despite ICERs below the threshold. In instances where decisions went against the ICER thresholds, there was a clear tendency for identifiable problems with the clinical and economic assumptions to diminish the reliability of the ICERs presented. This result highlights that a lower-than-threshold ICER is not enough for a positive recommendation and manufacturers must support their submission with accurate and reliable data to achieve a favourable outcome.

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CROSS-MARKETS VARIABILITY OF INNOVATION BENEFIT'S EVALUATIONS. HOW ITALY COMPARES TO FRANCE, GERMANY AND THE UNITED STATES

Savi L, Conti CC, Tangari M, Lim A

GfK Bridgehead, London, UK

OBJECTIVES: A new drugs' innovation benefit is commonly evaluated, both in Europe and the USA. Most of the new pharmaceutical launches have to be evaluated on the level of innovation that they offer as part of the market access process. The objective of this abstract is to give an example of the variability that emerges in the innovation scores given by the Italian agency, AIFA, as compared to those of France, Germany and the USA. **METHODS:** Drugs listed on the AIFA website as showing potential or important innovation, were used as a benchmark to measure how innovation benefit assessments performed in France, Germany and the USA deviate. The innovation benefit was measured through: the ASMR score (Amélioration du Service Médical Rendu) in France, as published on the HAS website (Haute Autorite' de Sante'); the level of additional benefit in Germany, as published on the G-BA website (Gemeinsame Bundesausschuss); the type of approval procedure as published on the FDA (Food and Drug administration) website. In the case of the USA, standard approval vs. priority review was used as a proxy measure of the level of innovation. **RESULTS:** The results of the innovation benefit's evaluations performed in France, Germany and the USA differ from those performed by AIFA in 74%, 33% and 58% of cases respectively. The lower percentage in Germany is due to limited available information compared to other markets. **CONCLUSIONS:** The level of variability that exists between the outcomes of the innovativeness evaluation performed in different countries suggests that although the definition of innovation may appear straightforward, it is open to different interpretations by different health care systems.

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NICE STA DECISIONS: AN ANALYSIS OF HOW ADVICE DIFFERS BETWEEN PRELIMINARY AND FINAL GUIDANCE

Murray G, McLeod C, Howells R

Abacus International, Manchester, UK

OBJECTIVES: The National Institute for Health and Care Excellence (NICE) established the Single Technology Appraisal (STA) programme to evaluate the clinical and cost-effectiveness of medical technologies and provide mandatory guidance on how they should be used within the National Health Service (NHS) in the UK. The objective of this analysis is to explore how NICE advice differs between preliminary and final guidance in the STA process and identify actions manufacturers could take to increase their chances of a successful submission. **METHODS:** For STAs published between February 2010 and May 2013, the appraisal consultation document (ACD) and final appraisal determination (FAD) were identified. The guidance issued in these documents was compared and contrasted, and the key clinical and economic evidence that affected recommendations were extracted into an Excel workbook. **RESULTS:** Of the 71 STAs published, ACDs were produced for 60 technologies, while 11 (15%) proceeded straight to FAD. All submissions which proceeded directly to FAD were recommended (full or optimised) in the final guidance. Twelve STAs (20%) received a "minded no" at ACD; however, 11 of these (92%) were reversed within the FAD on the basis of additional data provided by the manufacturers in the form of economic analyses (n=5) or patient access schemes (PAS) (n=6). Of the 35 "not recommended" at ACD, 15 (43%) were ultimately recommended within the FAD through the introduction or revision of a PAS and/or submission of additional analyses. **CONCLUSIONS:** If manufacturers can demonstrate a robust clinical and economic argument in their initial submission the chances of a FAD being produced without the requirement of an ACD are greatly increased. Furthermore, ACD decisions can also be overturned; technologies which receive a "minded no" or "not recommended" at ACD stage can achieve a recommendation at FAD by presenting additional analyses or introducing/modifying a PAS.

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COMPARISON OF DRUG ASSESSMENTS IN FRANCE, GERMANY AND THE UNITED KINGDOM: IS EUROPEAN HTA A REALITY?

Troubat A, Perrin L

IMS Health, PARIS LA DEFENSE, France

OBJECTIVES: In 2006, the EUnetHTA project was launched. One of its main strategic objectives was to strengthen the link between HTA and health care policy making in the EU. Seven years after EUnetHTA establishment, the objective of this study was to compare HTA agencies' assessments in France, Germany and UK, focusing on method and outcomes. **METHODS:** Scope of the study was all the products getting a positive opinion from CHMP during two years, starting at January 1, 2011. Comparison between assessments was made for products assessed by the three HTA agencies: IQWiG, NICE, and HAS. **RESULTS:** A total of 87 drugs were included in this study. 11 (13%) have been assessed by the three agencies. Among these drugs, more than 50% (6) were cancer treatment. HAS was the first to assess drug in 6 cases (mean delay between CHMP positive opinion and assessment: 223 days), followed closely by IQWiG (242 days), then by NICE (354 days). IQWiG segmented the patient population defined by the manufacturer into different sub-populations in 6 assessments, HAS in 2, NICE never. NICE was the only agency who did not recommend a drug for cost-effectiveness reasons (2 assessments). In three assessments, IQWiG concluded that there was no benefit proven for the whole population; regarding the same drugs, HAS concluded there was minor improvement in actual benefit twice. **CONCLUSIONS:** Some major trends emerge in the assessments studied: use of indirect comparisons, added therapeutic value weighted by severity and frequency of side effects and uncertainty. Nevertheless, comparator choices, perception of clinical benefits and risks, budget impact and overall method still differ between the three HTA agencies studied, leading to different outcomes for drugs assessed.

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USING THE DELPHI METHOD FOR SELECTING MEDICAL TECHNOLOGIES UNDER BUDGET CONSTRAINTS: A FEASIBILITY STUDY

Daichman S[1], Greenberg D[2], Triki N[3], Hammerman A[4], Luxenburg O[5], Pliskin JS[6]

[1]*SCE- Shamoon College of Engineering, Beer-Sheva, Israel*, [2]*Ben-Gurion University of the Negev, Beer-Sheva, Israel*, [3]*Maccabi Healthcare Services, Tel Aviv, Israel*, [4]*Clalit Health Services Headquarters, Tel Aviv, Israel*, [5]*Ministry of Health, Jerusalem, Israel*, [6]*Ben Gurion University of the Negev, Beer-Sheva, Israel*

OBJECTIVES: To examine whether the Delphi method can provide a convenient tool for selecting medical technologies for inclusion in the National List of Health Services (NLHS) in Israel under a pre-defined budget constraint. **METHODS:** The Delphi method was applied in two groups: medical specialists (oncologists and cardiologists) and observers in the NLHS committee. Participants in each group were anonymously asked to choose five of ten suggested technologies from the list of technologies submitted for inclusion in the 2012 NLHS and rank them according to importance. Subsequently, the participants repeated the experiment after receiving aggregated feedback on the relative ranking of each technology within the same group after the first round. Comparison of the results was performed using descriptive statistics and non-parametric tests. **RESULTS:** After two rounds of the experiment, observers and medical specialists reached agreement on four of the five highest ranked technologies in each field (oncology and cardiology) regarding their importance to be included in the NLHS. Three of these four technologies were indeed included in the NLHS for 2012. **CONCLUSIONS:** The Delphi method is one of the best-known techniques to control group interaction and reach a consensus by utilizing the expertise of committee members. The study demonstrated the feasibility using the Delphi method for ranking health care technologies.

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WHICH SHOULD BE THE CORRECT NMA TO BE USED? A REVIEW OF HTA RECOMMENDATIONS

Solozabal M[1], Roset M[1], Rojas-Farreras S[1], González-Rojas N[2], Gil A[2]

[1]*IMS Health, Barcelona, Spain*, [2]*Boehringer Ingelheim, Sant Cugat del Vallès (Barcelona), Spain*

OBJECTIVES: In the lack of head-to-head comparative trials to demonstrate the efficacy of new treatments, it is common to use network meta-analysis (NMA), including indirect treatment comparison (ITC) or combine direct and indirect evidence through mixed treatment comparison (MTC). Due to the increasing number of drugs approved for the same indication and the increasing complexity of networks for treatments comparisons, new methods of MTC taking into account all the comparisons have aroused. Health Technology Assessment (HTA) bodies increasingly demand NMA although different recommendations about the methodologies to be applied exist. This study aims to review recommendations regarding ITCs and MTCs among the main HTA bodies. **METHODS:** A review of methodologies for drug comparison recommended by the main HTA bodies was performed. Recommendations related to evidence identification methods, assessment of homogeneity of studies and populations to be combined and statistical approach for the analysis were also reviewed. **RESULTS:** A systematic literature search is a prerequisite for most HTA bod-